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World AIDS Day — December 1, 2004

World AIDS Day 2004 focuses on the increasing vulnerability of women to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) with the theme, Women, Girls, HIV, and AIDS. Globally, women account for nearly half of adults living with HIV. However, in some African countries, HIV prevalence is nearly five times greater among young women than men (*1*).

In the United States, women in racial/ethnic minority populations are especially vulnerable. In 2003, black and Hispanic women accounted for 25% of all U.S. women but 83% of women with diagnosed AIDS (*2*). Black women were 25 times more likely and Hispanic women six times more likely than white women to have diagnosed AIDS (*2*).

In 2002, surveys of U.S. adults indicated that one tenth had been tested for HIV during the previous year (*3*). CDC estimates one fourth of the approximately 900,000 persons living with HIV in the United States do not know that they are infected, are not receiving treatments, and might unknowingly transmit HIV to others (*4*).

CDC supports a combined biomedical and behavioral strategy to reduce HIV infections in the United States, including expanded access to counseling, behavioral interventions, and screening and treatment for sexually transmitted diseases. Additional information is available at http://www.cdc.gov/hiv or by telephone, 800-342-2437.

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Introduction of Routine HIV Testing in Prenatal Care — Botswana, 2004

In 2003, approximately 37% of pregnant women in Botswana (2001 population: 1.7 million; approximately 40,000 births per year) (*1*) were infected with human immunodeficiency virus (HIV) (*2*). Since 2001, all prenatal clinics in Botswana have offered HIV screening and interventions for prevention of mother-to-child transmission of HIV (PMTCT), which can decrease vertical transmission of HIV from 35%–40% to 5%–10% (*3*). Historically, HIV testing in Botswana has been performed after individual pretest counseling, with patients actively choosing whether to be tested (i.e., an "opt-in" approach). In 2003, 52% of pregnant women receiving prenatal care nationwide learned their HIV status. In 2004, to increase use of free national PMTCT and antiretroviral treatment (ARV) programs, Botswana began routine, noncompulsory (i.e., "opt-out") HIV screening in prenatal and other health-care settings. Concerns have been raised that routine testing in Africa might deter women from seeking prenatal care and might result in fewer women returning for their test results and HIV care after testing. To assess the early impact of routine testing on HIV-test acceptance and rates of return for care, the CDC Global AIDS Program and the PMTCT program in Botswana evaluated routine prenatal HIV testing at four clinics in Francistown, the second largest city in Botswana, where HIV prevalence has been ≥40% since 1995. This report describes the results of that assessment, which indicated that, during February–April 2004, the first 3 months of routine testing, 314 (90.5%)

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of 347 pregnant women were tested for HIV, compared with 381 (75.3%) of 506 women during October 2003–January 2004, the last 4 months of the opt-in testing period ($p<0.001$). However, many women who were tested never learned their HIV status because of logistical problems or not returning to the clinic. Substantial increases in HIV testing of pregnant women were also observed at the Francistown referral hospital and at prenatal clinics nationwide. These findings highlight the potential public health impact of routine HIV testing with rapid, same-day results for programs seeking to increase the number of persons with access to HIV-prevention and treatment services.

Clinic Evaluation

In February 2004, in accordance with the new national policy of routine HIV testing in Botswana, personnel in four selected clinics were trained in a routine approach to prenatal HIV testing. Under the new system, existing PMTCT counselors (secondary-school graduates with 4 weeks of HIV-counseling training) held 10- to 15-minute group education sessions with pregnant women, using a flip chart as a discussion guide. The discussion focused on HIV transmission, PMTCT, ARV therapy, and testing needed for all mothers and infants. Women were informed that they would be routinely screened for HIV and other diseases. All were informed of their right to refuse testing. Women who did not want any of the tests were encouraged to discuss their concerns with the counselor. Women who arrived for prenatal care when no group could be convened received the same education individually. Women who did not refuse had blood drawn for HIV testing, which was performed offsite by laboratory technicians. Women usually received results and posttest counseling at their next scheduled prenatal visit (normally 1 month later). Women who were tested received individual posttest counseling, with a focus on PMTCT interventions for women who were identified as HIV positive, and were advised regarding next steps in medical care and psychosocial support.

Data on prenatal-care attendance, HIV test acceptance, and receipt of HIV test results were collected from clinic logbooks for the 4 months before the routine testing project began and for the first 3 months of routine testing. The median number of women beginning prenatal care at all four clinics was 114 per month (range: 95–134 women) during the opt-in testing period and 130 (range: 97–154 women) during the routine testing period, with a total of 859 women beginning care during the period of data collection. Six women who were known to be HIV positive before their first prenatal visit were excluded from this analysis. The median time for HIV test results to return from the laboratory was 19 days (range: 0–59 days).

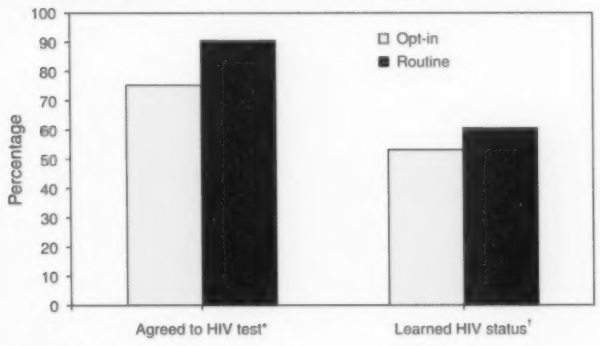
Acceptance of HIV testing and receipt of test results increased (Figure) after the introduction of routine testing. However, no difference was observed in the percentage of women who were tested but did not receive results between the opt-in and routine periods (29.4% versus 33.0%; p=0.29). Of all 639 women for whom test results were available, 306 (47.9%) were HIV positive.

Referral Hospital and National Program Data

Data from other sources also indicated an increase in the number of pregnant women learning their HIV status since routine testing began. Nyangabgwe Referral Hospital in Francistown is the site of approximately 10% of Botswana's annual deliveries, serving women from Francistown (including the four clinics involved in this project and eight other clinics where staff were trained in routine testing by project staff) and surrounding rural areas. For women who do not know their HIV status at delivery, routine testing is performed on the postnatal ward. Data from postnatal ward logbooks indicated that the percentage of women who delivered at Nyangabgwe Referral Hospital who knew their HIV status at the time of discharge increased from 50% in 2003 to 76% during the first 9 months of 2004. Data reported by all 24 health districts to the national PMTCT program indicated that the percentage of women who delivered in health facilities who knew their HIV status increased from 52% in 2003 to 69% during the first 6 months of 2004.

As a complement to routine HIV testing, the government of Botswana plans to train HIV counselors in all health facilities to perform rapid, onsite HIV testing. This measure should reduce the number of clients who are tested but never receive results.

FIGURE. Percentage of pregnant women who agreed to a human immunodeficiency virus (HIV) test at a prenatal clinic and who learned their HIV status within 60 days, by type of HIV-testing system — Francistown, Botswana, 2003–2004



*p≤0.001.
†p=0.03.

Reported by: *K Seipone, MD, Family Health Div, Botswana Ministry of Health; R Ntumy, MBChB, M Smith, MPH, BOTUSA Project, Gaborone; H Thuku, MD, Francistown District Health Team; L Mazhani, MD, Nyangabgwe Hospital, Francistown, Botswana. T Creek, MD, N Shaffer, MD, PH Kilmarx, MD, Global AIDS Program, National Center for HIV, STD, and TB Prevention, CDC.*

Editorial Note: Botswana has one of the greatest HIV burdens in the world. To improve coverage and effectiveness for its national PMTCT and ARV programs, Botswana recently adopted a national policy of routine HIV testing in prenatal and other health-care settings. The findings in this report demonstrate that group education and routine HIV testing were largely acceptable to this population of pregnant women in Botswana. Approximately 90% of women had an HIV test, and the introduction of routine testing did not lead to reductions in the number of women attending prenatal care or the percentage receiving test results compared with the opt-in period. Under both testing paradigms, many women who were tested did not learn their HIV status because laboratory testing was conducted offsite and results were not immediately available. Approximately 20% of women in Francistown never return to the clinic where they first seek prenatal care (Francistown District Health Team, unpublished data, 2002). Some women return but choose not to receive their results, and laboratory, clerical, and staffing difficulties add to the number of women who do not receive results during pregnancy.

Interventions to prevent mother-to-child transmission of HIV are effective and safe (*4*), and HIV-infected women who know their status can also receive life-sustaining ARV therapy. Without intervention, 35%–40% of HIV-positive women transmit HIV to their infants; however, drug prophylaxis and formula feeding can reduce transmission to 5%–10%, and combination ARV therapy can reduce transmission to <1% (*3*). For these reasons, routine HIV testing has become the standard of care for pregnant women in developed countries (*5*), where HIV seroprevalence is relatively low. A routine approach to HIV testing has been rare in Africa, where HIV prevalence is higher, stigma associated with an HIV diagnosis has been a barrier to test acceptance, and large-scale PMTCT and ARV treatment programs are only recently becoming available. As part of worldwide efforts to expand access to PMTCT and ARV therapy, routine HIV testing of pregnant women (with the right to refuse) is recommended in the 2004 joint United Nations and World Health Organization policy statement on HIV testing (*6*).

The findings in this report are subject to at least two limitations. First, this project involved clinics that had substantially higher-than-average testing acceptance even before implementation of the routine testing policy. Project clinics reported 76% acceptance at a time when the national program reported 52% acceptance; this was likely attributable to their highly committed staff. Second, data are being collected but are not yet available to determine whether women tested for HIV under the routine testing policy accept PMTCT interventions at the same rate as women tested under an opt-in testing policy.

Introduction of routine HIV testing can improve HIV testing participation and access to prevention and treatment services in prenatal and other clinical settings. Use of same-day, rapid HIV testing can increase the impact of such a strategy in settings in which patients might not receive results from offsite testing.

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Two Cases of Hantavirus Pulmonary Syndrome — Randolph County, West Virginia, July 2004

Hantavirus pulmonary syndrome (HPS) is a rare cardiopulmonary disease caused by viruses of the genus *Hantavirus*, for which rodents are the natural reservoir (*1*,*2*). Transmission to humans occurs by direct contact with rodents or their excreta or by inhalation of aerosolized infectious material (e.g., dust created by disturbing rodent nests). In July 2004, HPS cases (including one fatal case) were reported in two persons believed to have been exposed at sites approximately 12 miles apart in Randolph County, West Virginia (2000 population: 28,254) (*3*). This report describes the two cases and summarizes their epidemiologic and environmental investigations. Clinicians and the public need to be educated about the risk for HPS and methods to reduce that risk.

Case Investigations

Patient A. In early July, a wildlife sciences graduate student, a man aged 32 years, visited an emergency department (ED) in Blacksburg, Virginia, with complaints of fever, cough, and sore chest since the previous evening. The ED clinician noted possible rodent exposure in the medical history of the patient. Examination revealed a temperature of 102.7°F (39.3°C) and an oxygen saturation of 96% (normal). A complete blood count (CBC) revealed a left shift with no bands (granulocytes: 87%) and lymphopenia (lymphocytes: 400/mm^3). Radiographic examination indicated faint right-sided pneumonia. In the ED, the graduate student began vomiting and was admitted for intravenous hydration and parenteral antibiotics. He became progressively hypoxic, requiring supplemental oxygen, bilevel positive airway pressure, and eventually intubation with mechanical ventilation. Repeated radiographs revealed bilateral pulmonary edema.

The next day, the patient was hypotensive, requiring intravenous pressor support. He received activated protein C to prevent disseminated intravascular coagulation (DIC). A repeat CBC revealed bands (granulocytes: 20%) and a decreased platelet count (115,000/mm^3); urinalysis indicated mild hematuria and proteinuria. Despite aggressive supportive care, the patient's status continued to deteriorate, and he died on the third day of his hospitalization. Differential diagnosis included tularemia, pneumococcal sepsis, and HPS. Serum specimens submitted to ARUP Laboratories (Salt Lake City, Utah) were positive for both IgG and IgM antibodies to hantaviruses; these test results were confirmed by CDC. A spleen biopsy was also positive by immunohistochemistry for hantavirus antigens. A serum sample was positive for hantavirus RNA by real-time reverse transcriptase-polymerase chain reaction (RT-PCR). Sequencing of the amplified nucleic acid identified the virus as Monongahela hantavirus (*4*).

According to interviews with his coworkers, the patient had spent the previous month trapping small mammals for study and handling mice (*Peromyscus* spp.) daily. Two students and a recent graduate who had worked with the patient reported that none of them had consistently worn gloves while handling rodents or washed their hands after handling rodents or their excreta, even before eating. The students also reported frequent rodent bites on their bare hands.

Patient B. In early July, a Randolph County resident, a man aged 41 years, spent a weekend at a log cabin with his family. Two days later, he had fatigue, a dull headache, and a mild fever. The following day, he had a temperature of 102.9°F (39.4°C). The next morning, he visited his primary-care

up-to-the-minute: *adj*

1 : extending up to the immediate present, including the very latest information; see also *MMWR*.

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physician with hematuria but no fever and was released on empiric antibiotic therapy for a possible urinary tract infection.

The patient returned 2 days later with a severe headache of approximately 12 hours' duration; he was referred immediately to the local ED. On arrival, the patient was hypoxic with a room air oxygen saturation of 90%; chest radiographs revealed right-sided pneumonia and congestive heart failure. The patient was airlifted to a referral hospital, with hypotension and bradycardia. His white blood cell count was normal, and cardiac enzymes were negative. The patient was placed in the intensive care unit and administered intravenous pressors and broad-spectrum antibiotics. Differential diagnosis included viral myocarditis, atypical pneumonia, and opportunistic infection, and was later broadened to include HPS and other infectious and autoimmune etiologies.

The patient was intubated the next day and started on high-frequency oscillator ventilatory support. The patient's condition deteriorated, with onset of thrombocytopenia, DIC, hypoalbuminemia, and renal insufficiency requiring hemodialysis. After 5 days of hospitalization, his condition began to improve. Serum samples were reported positive for IgG and IgM antibodies to hantaviruses by ARUP Laboratories; these results were confirmed by CDC. In addition, a serum sample taken during his hospitalization was positive for hantavirus RNA by RT-PCR. Sequencing of the amplified nucleic acid also identified the virus as Monongahela hantavirus. The patient recovered slowly during the next month.

According to family members, when the patient and his family arrived at the cabin in early July, they aired the interior after finding it reeking of rodent urine and discovered two live mice in a trash can in the kitchen. The patient killed the mice and later disposed of the remains and cleaned the trash can without wearing gloves. The family slept in the cabin that weekend and trapped six additional mice during their stay.

Environmental Investigation

On August 3, investigators from CDC and the West Virginia Department of Health and Human Resources discovered additional live mice in the trash can in the cabin of patient B. Openings in the walls and eaves were identified that permitted easy entry by rodents. In all, rodents were trapped by the investigating team during August 3–6 from three rural sites in Randolph County: 1) the dormitory in which patient A lived and its surroundings, 2) a forest trapping site where patient A worked the week before his illness, and 3) the family cabin and surroundings of patient B. Fourteen white-footed mice (*P. leucopus*) and one deer mouse (*P. maniculatus*) were captured from 239 traps during a 3-day period. Tissue and blood specimens were collected and processed for serology. RT-PCR was conducted on specimens of rodents with positive serology results. Hantavirus antibodies were detected in one white-footed mouse, which was also positive for virus RNA by RT-PCR. Sequence of the amplified RNA indicated that the mouse was infected with Monongahela hantavirus identical to virus identified in rodents collected from the location where patient B was presumed to have been infected. The amplified nucleic acid sequence was similar, but not identical, to that amplified from patient A.

Reported by: *Randolph County Dept of Health; J Rooney, DVM, West Virginia Dept of Health and Human Resources. K McCombs, MPH, New River Health District, Virginia Dept of Health. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; B Pavlin, MD, J Sinclair, DVM, EIS officers, CDC.*

Editorial Note: Since HPS was first identified in the southwestern United States in 1993, a total of 379 laboratory-confirmed cases of HPS have been reported in the United States, including 32 retrospectively identified cases that occurred before 1993. Cases have been reported in 31 states, the majority of cases in the Southwest. Three cases of HPS have been identified as acquired in West Virginia. Subclinical infections are rare, according to antibody prevalence studies performed after the 1993 outbreak (*5–7*).

In the first case described in this report, exposure was probably occupational. Patient A regularly handled multiple mice, often suffered bites, and reportedly did not routinely wash his hands after handling rodents. In the second case, the exposure was peridomestic, likely associated with contact with live mice and their excreta while removing them from his cabin. Despite the temporal and geographic proximity of the two cases, no common exposure source, other than the rodent contact described, appears to exist.

These cases underscore the need to educate the public and clinicians about the risk for HPS in areas outside the Southwest. In addition, persons who have occupational exposure to rodents and their excreta should be trained in proper animal handling and use of personal protective equipment. Simple, effective methods are available to reduce exposure to hantaviruses (Box). Adherence to these precautions can reduce the incidence of HPS.

Acknowledgments

The report is based on data provided by P Keyser, PhD, MeadWestvaco Corporation, Elkins; M Fisher, MD, Ruby Memorial Hospital, Morgantown; J Crum, PhD, West Virginia Div of Natural Resources. M Kelly, PhD, Dept of Fisheries and Wildlife Science, Virginia Polytechnic Institute and State Univ, Blacksburg, Virginia.

BOX. Epidemiology, diagnosis, treatment, and prevention of hantavirus pulmonary syndrome (HPS)

Epidemiology

- Zoonotic disease caused by viruses in the genus *Hantavirus*
- Transmitted to humans by exposure to excreta of infected rodents
- Incubation period: 1–5 weeks
- Cases reported throughout the United States
- U.S. case-fatality rate: 37%

Clinical and laboratory findings

- Prodrome of fever, myalgias, cough, and nausea/vomiting
- Rapid progression after the prodrome to pulmonary edema and nonischemic, cardiogenic shock
- Acute respiratory distress syndrome on chest raiograph
- Thrombocytopenia and hemoconcentration
- Confirmation by serology; additional confirmation by immunohistochemistry or reverse transciptase-polymerase chain reaction

Treatment

- Intensive supportive care, including early intubation and mechanical ventilation; intravenous pressors
- Early placement of pulmonary artery catheter
- Judicious volume resuscitation
- No specific antiviral treatment available

Prevention

- Find and seal rodent entry-holes in building
- Trap rodents in and around building using snap traps
- Before handling dead rodents, rodent feces, nests, or contaminated surfaces, spray thoroughly with a household disinfectant or diluted household bleach (one part bleach added to nine parts tap water)
- Wear disposable gloves when handling rodents or their excreta and wash hands immediately afterwards
- Report suspected cases to state health department
- Additional information is available at http://www.cdc.gov/hantavirus or refer to http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5109a1.htm.

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Serious Psychological Distress Among Persons with Diabetes — New York City, 2003

"Depression, anxiety, and other disorders causing serious psychological distress (SPD) frequently complicate the health care of persons with diabetes (*1–3*)." To assess the prevalence and effects of SPD among adults with diabetes, the New York City Department of Health and Mental Hygiene (DOHMH) analyzed data from approximately 10,000 adults who participated in the 2003 New York City Community Health Survey (CHS). The results indicated that 1) adults with diabetes were twice as likely to have SPD as those without diabetes, and 2) adults with both SPD and diabetes were more likely than those with only diabetes to live in poverty, report poor health, lack access to health care, and to have lost a spouse or partner to separation, divorce, or death. An integrated program of physical and mental health care that addresses socioeconomic barriers and improves access to treatment might improve the overall health of persons with diabetes and SPD.

CHS is a random-digit–dialed telephone survey of noninstitutionalized New York City adults aged ≥18 years, conducted by DOHMH. The findings described in this report are from interviews in 2003 with 9,802 respondents (response rate: 59% of the 16,752 households contacted); a total of 9,590 persons provided complete data and were included as participants in the study. Interviews were conducted in 23 languages; the study was approved by an institutional review board.

The survey was adapted from the Behavioral Risk Factor Surveillance System (BRFSS) survey and National Health Interview Survey. Diabetes was determined by using the modified BRFSS question, "Have you ever been told by a doctor that you have diabetes?" Respondents with positive responses that were not pregnancy related were classified as having

diabetes. SPD was determined by using the K6 scale, a psychometrically validated, epidemiologic screening measure that is highly correlated with diagnostic measures of major depressive disorder, generalized anxiety disorder, schizophrenia, and other mental disorders (*4*). Respondents were asked how often during the preceding 30 days they felt "sad," "nervous," "restless," "hopeless," "worthless," or that "everything was an effort." Responses to these six feelings were measured on a scale of 0–4 (range: 0–24). Responses were summed and participants with scores ≥13 were classified as having SPD (*5*).

Analyses were conducted by using statistical analysis software to account for the complex survey design. Prevalence estimates were adjusted to the 2000 U.S. standard census distribution, and 95% confidence intervals (CIs) were generated. Logistic regression was used to compute age-adjusted odds ratios (AORs) and to determine whether diabetes was an independent risk factor for SPD.

Among all 9,590 participants, 498 had SPD, an age-adjusted prevalence of 5.0% (95% CI = 4.5–5.6). Among the 857 (9.0%) participants with diabetes, 80 had SPD, a prevalence of 10.4% (CI = 7.3–14.7). After controlling for age, sex, race/ethnicity, marital status, and household income, participants with diabetes were twice as likely as participants without diabetes to have SPD (AOR = 1.9; CI = 1.4–2.8).

Adults with diabetes and SPD were more likely than adults with only diabetes to be divorced, separated, or widowed (48.7% versus 25.3%) or to have household incomes below $25,000 (70.2% versus 42.8%) (Table). Moreover, adults with diabetes and SPD reported poorer health-care utilization than adults with only diabetes. Only 11% of adults with diabetes and SPD had private insurance, compared with 41.6% of adults with only diabetes. Adults with both conditions also were more likely than adults with only diabetes to report not filling a prescription or seeing a doctor for a medical problem because of cost (42.0% versus 16.5% and 47.1% versus 23.1%, respectively). Adults with both conditions were also more than twice as likely as adults with only diabetes to use an emergency department as their usual source of health care (25.6% versus 9.8%) (Table).

Self-reported health status was worse for adults with both diabetes and SPD, compared with adults with only diabetes. Fair or poor health was reported by 78.2% of adults with diabetes and SPD, compared with 39.8% of those with only diabetes. In addition, adults with both diabetes and SPD were three times as likely than those with only diabetes (64.2% versus 22.2%) to report ≥3 days during the preceding 30 days, when poor physical health limited their usual activities, and seven times as likely (63.3% versus 9.1%) to report similar limitations attributed to poor mental health (Table).

Reported by: *KH McVeigh, PhD, F Mostashari, MD, LE Thorpe, PhD, Div of Epidemiology, New York City Dept of Health and Mental Hygiene. National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: Diabetes and other chronic diseases (e.g., hypertension and asthma) have been associated with higher rates of SPD (*1–3,6,7*). The findings in this report are consistent with previous studies of diabetes that have suggested SPD occurs twice as often among persons with diabetes as among the general population, usually in the form of depression or depressive symptomatology (*1–3*). The findings regarding the use of health-care services by persons with diabetes and depression compared with persons with only diabetes are consistent with other studies that have associated having diabetes and depression with poor physical and mental functioning, increased use of the emergency department, and poor adherence to medication regimens (*8,9*). Pharmacologic and nonpharmacologic mental health treatments have been shown to reduce depressive symptomatology in persons with both diabetes and depression; however, evidence conflicts regarding whether they improve glycemic control (*10*).

The findings in this report are subject to at least three limitations. First, the sample represents only noninstitutionalized adults with telephones. Second, the cross-sectional nature of the study prevents determining whether SPD preceded or followed the onset of diabetes. Finally, the data are self-reported, and measures of glycemic control, self-care practices, severity of diabetes, and diagnostic measures to distinguish the exact type of SPD were not available.

Persons with comorbid diabetes and SPD face formidable economic and social obstacles to receiving appropriate health care. Increased use of more effective methods for detecting and managing depression and other mental disorders might be particularly beneficial for persons with diabetes. Research is needed to assess the effects of these methods on diabetes and mental health outcomes.

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TABLE. Demographic, health-care utilization, and health-status characteristics of adults with diabetes, by serious psychological distress (SPD) status — New York City Community Health Survey, 2003

Characteristic	Adults with diabetes* With SPD (n = 80) %	Without SPD (n = 777) %	Age-adjusted odds ratio	(95% CI†)
Age group (yrs)				
18–44	21.9	16.5	(ref§)	
45–64	55.9	46.7	0.9	(0.4–2.0)
≥65	22.3	36.8	0.5	(0.2–1.1)
Sex				
Men	55.5	55.1	(ref)	
Women	44.5	44.9	1.0	(0.5–1.8)
Race/Ethnicity				
White, non-Hispanic	18.3	23.9	(ref)	
Black, non-Hispanic	23.0	25.1	0.7	(0.3–1.5)
Hispanic	45.2	33.5	1.9	(1.0–3.8)
Asian/Pacific Islander	12.7	14.3	0.6	(0.2–2.6)
Other	0.8	3.2	0.2	(0.0–1.8)
Marital status				
Married/Partnered	33.4	51.7	(ref)	
Divorced/Separated/Widowed	48.7	25.3	3.2	(1.7–6.1)
Never married	18.0	23.0	1.9	(0.6–5.6)
Household income				
<$25,000	70.2	42.8	6.4	(1.7–24.5)
$25,000–$49,999	9.6	28.7	1.4	(0.3–6.0)
≥$50,000	3.5	16.7	(ref)	
Unknown	16.7	11.8	5.6	(1.3–23.7)
Health-care insurance				
Private insurance	11.0	41.6	(ref)	
Medicaid/Medicare insurance	67.7	45.8	5.5	(2.6–11.9)
Uninsured	21.3	12.6	4.5	(1.4–14.3)
Because of cost				
Did not fill a prescription	42.0	16.5	3.2	(1.7–5.9)
Did not go to a doctor when had a medical problem	47.1	23.1	2.9	(1.5–5.5)
Usual source of medical care				
Primary-care physician	45.4	62.9	(ref)	
Emergency department	25.6	9.8	3.5	(1.6–7.8)
Had a primary-care physician	82.3	77.9	1.4	(0.6–3.5)
Health status				
Good or excellent health	21.8	60.2	(ref)	
Fair or poor health	78.2	39.8	5.8	(2.9–11.6)
Days of limited activity caused by poor physical health¶				
≤3	35.8	77.8	(ref)	
>3	64.2	22.2	7.0	(3.9–12.6)
Days of limited activity caused by poor mental health¶				
≤3	36.7	90.9	(ref)	
>3	63.3	9.1	14.8	(7.5–29.2)
Smoking status				
Never smoker	53.0	57.1	(ref)	
Current smoker	23.2	19.6	1.7	(0.9–3.4)
Overweight or obese (BMI ≥25.0)**	81.6	68.9	1.8	(0.8–4.2)
No physical activity¶	50.7	39.0	1.6	(0.9–3.0)

* All estimates are age-adjusted to the 2000 U.S. standard population.
† Confidence interval.
§ Reference value.
¶ During the preceding 30 days.
** Body mass index.

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Notice to Readers

Epidemiology in Action: Intermediate Methods Course

CDC and the Rollins School of Public Health at Emory University will cosponsor a course, Epidemiology in Action: Intermediate Methods, February 21–25, 2005, at Emory University in Atlanta, Georgia. The course is designed for practicing public health professionals who have had training and experience in basic applied epidemiology and would like to learn additional quantitative skills related to analysis and interpretation of epidemiologic data.

The course is a review of the fundamentals of descriptive epidemiology and biostatistics, measures of association, normal and binomial distributions, confounding, statistical tests, stratification, logistic regression, models, and use of computers in epidemiology.

Prerequisite is an introductory course in epidemiology, such as Epidemiology in Action, International Course in Applied Epidemiology, or another introductory class. Tuition is charged. The application deadline is January 15, 2005. Additional information and applications are available from Pia Valeriano, Emory University, Rollins School of Public Health, International Health Department, 1518 Clifton Road N.E., Room 746, Atlanta, GA, 30322; telephone 404-727-3485; fax 404-727-4590; website http://www.sph.emory.edu/epicourses; or e-mail pvaleri@sph.emory.edu.

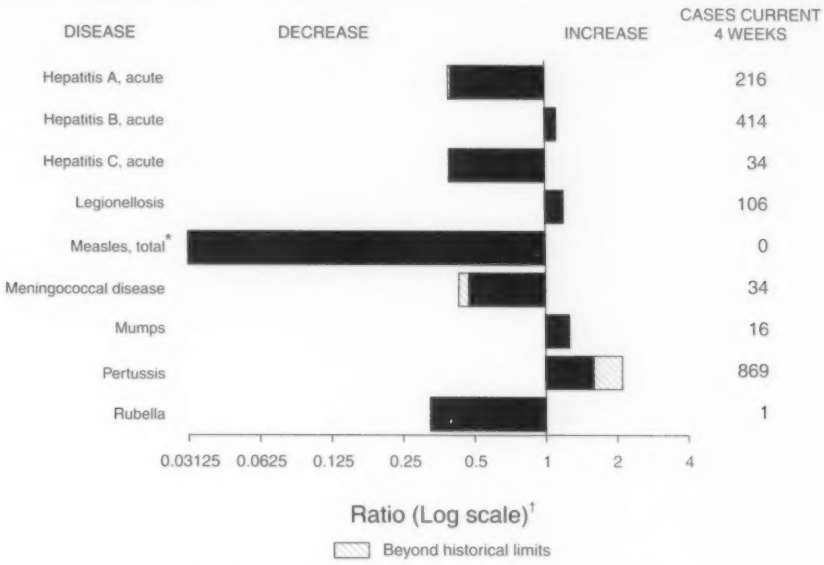
Notice to Readers

Epi Info: A Course to Develop Public Health Software Applications

CDC and the Rollins School of Public Health at Emory University will cosponsor Epi Info: A Course to Develop Public Health Software Applications, March 7–9, 2005, at Emory University in Atlanta, Georgia. The course is designed for public health practitioners who have intermediate to advanced skills in computing and wish to develop public health software applications using Epi Info for Windows 98, NT, 2000, and XP.

The 3-day course covers using the new Windows version of Epi Info, programming Epi Info software at an intermediate level, and computerized interactive exercises for developing public health information systems. Tuition is charged. Additional information and applications are available from Pia Valeriano, Emory University, Rollins School of Public Health, International Health Department, 1518 Clifton Road N.E., Room 746, Atlanta, GA, 30322; telephone 404-727-3485; fax 404-727-4590; website http://www.sph.emory.edu/epicourses; or e-mail pvaleri@sph.emory.edu.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 20, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 46 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 20, 2004 (46th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	HIV infection, pediatric[¶]	140	179
Botulism:	-	-	Influenza-associated pediatric mortality**	-	NA
foodborne	12	12	Measles, total	22[††]	52[§§]
infant	66	63	Mumps	191	195
other (wound & unspecified)	9	27	Plague	1	1
Brucellosis†	99	89	Poliomyelitis, paralytic	-	-
Chancroid	33	51	Psittacosis†	9	12
Cholera	4	1	Q fever†	64	59
Cyclosporiasis†	206	63	Rabies, human	4	2
Diphtheria	-	1	Rubella	11	7
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE)†	299	294	SARS-associated coronavirus disease† **	-	8
human monocytic (HME)†	283	247	Smallpox† [¶¶]	-	NA
human, other and unspecified	32	40	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† [¶¶]	-	NA
California serogroup viral† §	81	108	Vancomycin-resistant (VRSA)† [¶¶]	1	NA
eastern equine† §	4	13	Streptococcal toxic-shock syndrome†	90	141
Powassan† §	-	-	Tetanus	16	17
St. Louis† §	8	41	Toxic-shock syndrome	108	109
western equine† §	-	-	Trichinosis	4	3
Hansen disease (leprosy)†	73	72	Tularemia†	82	79
Hantavirus pulmonary syndrome†	17	20	Yellow fever	-	-
Hemolytic uremic syndrome, postdiarrheal†	130	155			

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 24, 2004.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 22 cases reported, 10 were indigenous, and 12 were imported from another country.
§§ Of 52 cases reported, 31 were indigenous, and 21 were imported from another country.
¶¶ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile§	
	Cum. 2004¶	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	34,915	38,111	768,148	763,155	5,352	3,477	2,957	3,051	837	2,855
NEW ENGLAND	1,149	1,276	26,135	24,549	-	-	155	172	-	31
Maine	23	49	1,849	1,755	N	N	18	19	-	-
N.H.	41	34	1,522	1,389	-	-	30	21	-	2
Vt.	14	15	890	946	-	-	23	29	-	-
Mass.	435	518	11,882	9,752	-	-	53	73	-	12
R.I.	115	89	2,971	2,632	-	-	4	15	-	5
Conn.	521	571	7,021	8,075	N	N	27	15	-	12
MID. ATLANTIC	7,373	8,995	93,771	94,519	-	-	486	390	17	223
Upstate N.Y.	792	825	19,891	17,516	N	N	169	116	5	-
N.Y. City	4,086	4,987	29,309	30,754	-	-	101	110	2	57
N.J.	1,230	1,362	13,034	14,097	-	-	31	17	1	21
Pa.	1,265	1,821	31,537	32,152	N	N	185	147	9	145
E.N. CENTRAL	2,858	3,543	132,519	139,182	15	7	833	916	61	150
Ohio	561	717	31,514	37,778	N	N	209	141	11	84
Ind.	339	482	16,008	15,087	N	N	80	87	5	15
Ill.	1,279	1,597	37,156	42,636	-	-	87	93	28	30
Mich.	537	584	32,584	27,996	15	7	145	131	12	14
Wis.	142	163	15,257	15,685	-	-	312	464	5	7
W.N. CENTRAL	727	687	47,990	44,131	6	2	375	542	80	696
Minn.	193	140	8,795	9,416	N	N	123	142	13	48
Iowa	58	75	5,900	4,418	N	N	82	118	11	81
Mo.	307	320	18,809	16,218	3	1	66	45	26	39
N. Dak.	15	3	1,316	1,411	N	N	12	12	2	94
S. Dak.	8	10	2,237	2,291	-	-	37	39	6	151
Nebr.**	41	49	4,556	4,130	3	1	27	24	4	194
Kans.	105	90	6,377	6,247	N	N	28	162	18	89
S. ATLANTIC	11,003	10,557	149,307	143,791	-	5	472	342	56	189
Del.	137	192	2,609	2,673	N	N	-	4	-	12
Md.	1,292	1,281	16,554	14,643	-	5	20	25	7	49
D.C.	785	858	2,875	2,787	-	-	12	13	1	3
Va.	567	813	18,879	17,200	-	-	58	41	4	19
W. Va.	73	78	2,435	2,299	N	N	6	4	-	1
N.C.	1,031	989	24,942	22,918	N	N	72	44	3	16
S.C.**	641	713	17,374	12,803	-	-	15	8	-	3
Ga.	1,407	1,665	26,740	31,607	-	-	169	106	12	27
Fla.	5,070	3,968	36,899	36,861	N	N	120	97	29	59
E.S. CENTRAL	1,654	1,699	50,352	48,917	4	1	114	123	57	90
Ky.	215	175	5,333	7,164	N	N	42	23	1	11
Tenn.**	684	733	19,554	18,021	N	N	29	38	13	21
Ala.	388	391	9,882	12,800	-	-	20	52	13	25
Miss.	367	400	15,583	10,932	4	1	23	10	30	33
W.S. CENTRAL	4,027	4,058	91,798	94,073	2	-	68	107	184	603
Ark.	182	164	6,330	6,984	1	-	16	17	12	23
La.	812	520	19,227	17,806	1	-	3	4	68	95
Okla.	173	177	9,116	10,117	N	N	20	16	11	56
Tex.**	2,860	3,197	57,125	59,166	N	N	29	70	93	429
MOUNTAIN	1,294	1,327	43,360	42,949	3,452	2,054	153	122	232	871
Mont.	6	13	2,045	1,832	N	N	34	18	2	75
Idaho	16	22	2,466	2,211	N	N	27	26	-	-
Wyo.	15	6	951	859	2	1	3	5	2	92
Colo.	288	327	10,591	11,514	N	N	53	33	39	621
N. Mex.	169	98	5,139	6,482	20	9	12	10	30	74
Ariz.	496	576	14,279	11,715	3,340	2,002	17	6	128	7
Utah	55	60	3,145	3,277	34	8	5	17	6	-
Nev.	249	225	4,744	5,059	56	34	2	7	25	2
PACIFIC	4,830	5,969	132,916	131,044	1,873	1,408	301	337	150	2
Wash.	352	420	15,599	14,568	N	N	36	43	-	-
Oreg.	250	229	7,248	6,556	-	-	31	36	-	-
Calif.	4,061	5,214	102,328	101,790	1,873	1,408	232	257	150	2
Alaska	51	18	3,232	3,319	-	-	-	1	-	-
Hawaii	116	88	4,509	4,811	-	-	2	-	-	-
Guam	2	5	-	536	-	-	-	-	-	-
P.R.	617	940	2,923	2,396	N	N	N	N	-	-
V.I.	17	31	272	370	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	32	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 31, 2004.

** Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	2,197	2,391	239	224	151	140	16,052	16,971	272,484	292,178
NEW ENGLAND	146	140	41	42	16	13	1,535	1,439	6,059	6,421
Maine	10	10	-	3	-	-	115	170	198	192
N.H.	21	18	5	3	-	-	44	36	112	112
Vt.	12	16	-	-	-	-	154	112	76	80
Mass.	62	62	10	8	16	13	669	743	2,794	2,545
R.I.	9	1	1	-	-	-	107	95	736	843
Conn.	32	33	25	28	-	-	446	283	2,143	2,649
MID. ATLANTIC	258	231	55	22	28	33	3,346	3,374	30,321	36,228
Upstate N.Y.	115	85	40	11	13	17	1,220	926	6,387	6,893
N.Y. City	35	7	-	-	-	-	864	1,078	9,402	12,022
N.J.	44	31	4	2	5	-	365	457	5,255	7,099
Pa.	64	108	11	9	10	16	897	913	9,277	10,214
E.N. CENTRAL	397	540	37	30	28	19	2,243	2,925	56,282	62,185
Ohio	94	126	10	16	21	19	720	808	16,313	19,951
Ind.	51	75	-	-	-	-	-	-	5,878	5,918
Ill.	64	120	2	2	1	-	468	850	16,433	19,174
Mich.	80	88	8	-	6	-	669	700	13,719	12,148
Wis.	108	131	17	12	-	-	386	567	3,939	4,994
W.N. CENTRAL	468	425	32	51	17	20	1,883	1,865	15,185	15,456
Minn.	111	126	15	21	1	1	705	701	2,640	2,690
Iowa	121	99	-	-	-	-	272	250	1,042	1,079
Mo.	84	78	11	17	7	1	490	465	8,081	7,727
N. Dak.	15	13	-	4	7	8	22	39	89	90
S. Dak.	31	28	2	4	-	-	58	73	253	196
Nebr.	67	48	4	5	-	-	144	132	923	1,377
Kans.	39	33	-	-	2	10	192	205	2,157	2,297
S. ATLANTIC	155	135	38	43	51	38	2,414	2,419	67,520	72,023
Del.	2	11	N	N	N	N	39	42	784	1,018
Md.	20	13	5	3	4	1	117	106	7,110	6,913
D.C.	1	1	-	-	-	-	60	46	2,164	2,216
Va.	35	36	17	12	-	-	482	319	7,517	7,999
W. Va.	2	5	-	-	-	-	40	40	799	762
N.C.	-	-	-	-	35	30	N	N	12,946	13,498
S.C.	7	2	-	-	-	-	51	128	8,478	7,562
Ga.	21	26	9	7	-	-	648	768	11,783	15,685
Fla.	67	41	7	21	12	7	977	970	15,939	16,370
E.S. CENTRAL	85	76	4	2	9	6	335	361	21,864	24,571
Ky.	24	25	2	2	6	6	N	N	2,388	3,198
Tenn.	31	33	2	-	3	-	157	167	7,429	7,490
Ala.	23	14	-	-	-	-	178	194	6,060	8,237
Miss.	7	4	-	-	-	-	-	-	5,987	5,646
W.S. CENTRAL	66	91	2	4	2	4	286	274	35,714	38,886
Ark.	14	12	1	-	-	-	111	137	3,174	3,717
La.	4	3	-	-	-	-	46	13	9,074	10,261
Okla.	17	28	-	-	-	-	129	124	3,879	4,161
Tex.	31	48	1	4	2	4	N	N	19,587	20,747
MOUNTAIN	228	296	29	26	-	7	1,376	1,437	9,396	9,209
Mont.	16	16	-	-	-	-	76	98	62	101
Idaho	49	78	16	15	-	-	179	181	83	65
Wyo.	9	4	5	1	-	-	22	20	58	39
Colo.	50	64	2	4	-	7	473	412	2,320	2,519
N. Mex.	9	11	2	5	-	-	62	49	736	1,036
Ariz.	23	36	N	N	N	N	163	221	3,482	3,229
Utah	48	64	3	-	-	-	295	327	485	347
Nev.	24	23	1	1	-	-	106	129	2,170	1,873
PACIFIC	394	457	1	4	-	-	2,634	2,877	30,143	27,199
Wash.	137	108	-	1	-	-	351	330	2,416	2,421
Oreg.	66	99	1	3	-	-	411	373	1,092	875
Calif.	180	237	-	-	-	-	1,718	2,016	25,093	22,336
Alaska	1	5	-	-	-	-	84	81	467	489
Hawaii	10	8	-	-	-	-	70	77	1,075	1,078
Guam	N	N	-	-	-	-	-	2	-	63
P.R.	1	1	-	-	-	-	119	299	214	246
V.I.	-	-	-	-	-	-	-	-	80	79
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype			
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,571	1,636	13	25	92	100	150	177	5,038	6,600
NEW ENGLAND	139	126	1	2	6	5	4	3	902	293
Maine	12	4	-	-	-	-	-	1	11	16
N.H.	18	12	-	1	2	-	1	-	26	16
Vt.	8	8	-	-	-	-	1	-	8	6
Mass.	53	61	1	1	-	5	2	1	773	165
R.I.	6	8	-	-	1	-	-	1	21	14
Conn.	42	35	-	-	3	-	-	-	63	76
MID. ATLANTIC	345	346	1	3	5	3	38	44	615	1,576
Upstate N.Y.	111	122	1	3	5	3	5	8	99	121
N.Y. City	73	61	-	-	-	-	14	11	240	409
N.J.	67	65	-	-	-	-	4	11	133	194
Pa.	94	98	-	-	-	-	15	14	143	852
E.N. CENTRAL	240	268	-	3	6	5	35	47	492	576
Ohio	91	63	-	-	2	-	15	11	45	106
Ind.	47	42	-	-	4	-	1	5	93	61
Ill.	50	97	-	-	-	-	11	21	170	171
Mich.	20	22	-	3	-	5	6	1	133	194
Wis.	32	44	-	-	-	-	2	9	51	44
W.N. CENTRAL	98	102	2	2	3	7	12	12	157	154
Minn.	43	44	1	2	3	7	1	2	32	37
Iowa	1	-	1	-	-	-	-	-	49	27
Mo.	34	36	-	-	-	-	7	9	39	52
N. Dak.	4	4	-	-	-	-	-	-	1	1
S. Dak.	-	1	-	-	-	-	-	-	3	-
Nebr.	9	2	-	-	-	-	2	-	10	12
Kans.	7	15	-	-	-	-	2	1	23	25
S. ATLANTIC	361	364	1	2	21	17	26	22	917	1,568
Del.	-	-	-	-	-	-	-	-	5	8
Md.	56	88	-	1	4	8	1	1	101	170
D.C.	-	1	-	-	-	-	-	-	7	38
Va.	35	51	-	-	-	-	1	6	120	93
W. Va.	15	15	-	-	1	-	3	-	6	14
N.C.	54	36	1	-	6	3	1	2	99	98
S.C.	4	6	-	-	-	-	-	2	24	35
Ga.	91	65	-	-	-	-	17	6	296	736
Fla.	106	102	-	1	10	6	3	5	259	376
E.S. CENTRAL	59	73	1	1	-	3	8	8	140	248
Ky.	5	6	-	-	-	2	-	-	29	29
Tenn.	38	44	-	-	-	1	6	5	80	181
Ala.	13	21	1	1	-	-	2	3	8	23
Miss.	3	2	-	-	-	-	-	-	23	15
W.S. CENTRAL	64	72	1	2	7	10	2	4	501	620
Ark.	3	6	-	-	-	1	1	-	56	32
La.	11	21	-	-	-	2	1	4	50	44
Okla.	49	42	-	-	7	7	-	-	19	20
Tex.	1	3	1	2	-	-	-	-	376	524
MOUNTAIN	174	154	4	6	25	23	18	16	406	422
Mont.	-	-	-	-	-	-	-	-	6	8
Idaho	5	4	-	-	-	-	2	1	20	16
Wyo.	1	1	-	-	1	-	-	-	5	1
Colo.	43	34	-	-	-	-	5	6	48	62
N. Mex.	35	17	1	-	7	4	5	1	20	21
Ariz.	61	76	-	6	12	10	2	4	247	231
Utah	16	12	2	-	2	5	3	4	47	35
Nev.	13	10	1	-	3	4	1	-	13	48
PACIFIC	91	131	2	4	19	27	7	21	908	1,143
Wash.	3	11	2	-	-	7	1	3	56	62
Oreg.	42	34	-	-	-	-	3	3	61	55
Calif.	34	56	-	4	19	20	1	9	761	1,005
Alaska	4	19	-	-	-	-	1	6	5	9
Hawaii	8	11	-	-	-	-	1	-	25	12
Guam	-	-	-	-	-	-	-	-	-	2
P.R.	-	1	-	-	-	-	-	1	24	74
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	Hepatitis (viral, acute), by type: B Cum. 2004	Hepatitis (viral, acute), by type: B Cum. 2003	Hepatitis (viral, acute), by type: C Cum. 2004	Hepatitis (viral, acute), by type: C Cum. 2003	Legionellosis Cum. 2004	Legionellosis Cum. 2003	Listeriosis Cum. 2004	Listeriosis Cum. 2003	Lyme disease Cum. 2004	Lyme disease Cum. 2003
UNITED STATES	5,719	6,211	744	951	1,658	1,920	575	593	15,856	18,433
NEW ENGLAND	324	320	12	8	54	109	40	47	2,460	3,620
Maine	2	1	-	-	-	2	7	7	53	149
N.H.	37	17	-	-	10	9	3	4	202	155
Vt.	5	4	7	8	6	6	2	1	47	42
Mass.	189	201	4	-	8	54	11	17	884	1,490
R.I.	5	13	-	-	15	14	1	-	197	529
Conn.	86	84	1	-	15	24	16	18	1,077	1,255
MID. ATLANTIC	1,126	673	131	116	479	552	135	120	10,606	12,158
Upstate N.Y.	83	84	15	15	105	137	44	32	3,629	4,008
N.Y. City	103	170	-	-	52	67	19	22	-	201
N.J.	679	166	-	-	92	81	23	22	3,018	2,748
Pa.	261	253	116	101	230	267	49	44	3,959	5,201
E.N. CENTRAL	488	465	107	133	440	410	88	78	803	889
Ohio	107	124	6	9	205	213	38	22	65	65
Ind.	38	33	8	8	71	27	16	8	18	21
Ill.	71	64	12	20	20	44	5	20	1	70
Mich.	240	201	81	91	129	108	26	19	33	9
Wis.	32	43	-	5	15	18	3	9	686	724
W.N. CENTRAL	283	294	46	225	50	62	19	15	537	379
Minn.	46	31	17	8	7	3	5	4	430	258
Iowa	14	11	-	1	5	9	3	-	44	49
Mo.	172	206	29	214	26	32	7	6	51	65
N. Dak.	4	2	-	-	2	1	-	-	-	-
S. Dak.	-	2	-	-	4	2	1	-	-	1
Nebr.	32	26	-	2	3	5	3	4	8	2
Kans.	15	16	-	-	3	10	-	1	4	4
S. ATLANTIC	1,677	1,794	145	135	353	483	100	119	1,255	1,126
Del.	28	10	-	-	12	25	N	N	137	196
Md.	150	120	15	9	71	125	15	24	723	667
D.C.	19	10	3	-	9	18	-	1	10	10
Va.	240	162	16	7	49	88	17	9	163	84
W. Va.	38	37	23	4	9	17	4	6	27	22
N.C.	168	148	11	11	35	36	22	16	112	95
S.C.	65	146	6	24	3	7	3	5	12	8
Ga.	518	604	15	13	36	33	14	30	13	10
Fla.	451	557	56	67	129	134	25	28	58	34
E.S. CENTRAL	387	416	87	77	85	96	21	29	44	60
Ky.	63	66	23	16	38	40	4	8	15	15
Tenn.	174	177	35	18	33	32	10	8	17	16
Ala.	64	88	5	6	11	19	5	11	3	8
Miss.	86	85	24	37	3	5	2	2	9	21
W.S. CENTRAL	388	988	112	150	56	72	27	48	31	90
Ark.	67	75	2	3	-	2	2	1	8	-
La.	59	109	65	98	4	1	3	4	4	6
Okla.	47	53	3	2	5	7	-	3	-	-
Tex.	215	751	42	47	47	62	22	40	19	84
MOUNTAIN	461	503	35	45	76	63	25	31	30	14
Mont.	2	16	2	2	2	4	-	2	-	-
Idaho	10	8	-	1	9	3	1	2	6	3
Wyo.	7	29	2	-	5	2	-	-	3	2
Colo.	55	71	-	11	19	10	12	9	-	-
N. Mex.	12	32	7	-	4	3	1	2	1	1
Ariz.	265	227	6	7	11	11	-	10	6	3
Utah	44	44	5	-	22	21	3	2	14	2
Nev.	66	76	13	24	4	9	8	4	-	3
PACIFIC	585	758	69	62	65	73	120	106	90	97
Wash.	47	67	21	18	10	10	9	7	13	3
Oreg.	99	101	14	13	N	N	6	4	32	15
Calif.	413	563	28	29	54	62	101	90	43	76
Alaska	15	5	-	-	1	-	-	-	2	3
Hawaii	11	22	6	2	-	1	4	5	N	N
Guam	-	9	-	5	-	1	-	-	-	-
P.R.	50	120	-	-	1	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,141	1,184	1,114	1,446	13,468	8,388	4,991	6,227	1,330	839
NEW ENGLAND	67	59	61	67	1,467	1,439	600	545	19	8
Maine	6	2	9	6	4	12	41	63	-	-
N.H.	5	6	7	4	90	90	29	25	-	-
Vt.	4	2	3	3	66	60	35	30	1	-
Mass.	34	29	33	41	1,264	1,196	265	198	15	8
R.I.	4	2	2	2	31	17	34	62	1	-
Conn.	14	18	7	11	12	64	196	167	2	-
MID. ATLANTIC	301	325	134	175	2,494	1,028	510	829	88	40
Upstate N.Y.	44	50	32	43	1,707	496	469	367	4	-
N.Y. City	158	174	24	39	154	131	12	6	20	13
N.J.	55	60	31	24	215	152	-	62	33	16
Pa.	44	41	47	69	418	249	29	374	31	11
E.N. CENTRAL	95	100	152	228	3,165	954	153	162	25	21
Ohio	28	20	61	53	530	242	74	51	13	9
Ind.	14	4	24	39	225	60	10	27	6	1
Ill.	23	42	12	67	422	88	49	24	2	5
Mich.	20	23	44	42	272	108	16	46	4	6
Wis.	10	11	11	27	1,716	456	4	14	-	-
W.N. CENTRAL	63	44	81	116	1,799	411	457	599	121	62
Minn.	25	20	23	26	437	141	84	36	3	1
Iowa	4	5	16	25	171	132	100	97	1	2
Mo.	19	6	19	45	286	76	58	40	96	49
N. Dak.	3	1	2	1	712	7	57	54	-	-
S. Dak.	1	3	2	1	43	5	10	125	4	5
Nebr.	4	-	4	7	43	11	53	94	17	4
Kans.	7	9	15	11	107	39	95	153	-	1
S. ATLANTIC	303	291	196	241	598	606	1,768	2,434	693	489
Del.	6	2	3	8	8	9	9	57	4	1
Md.	70	67	10	24	112	79	291	321	70	103
D.C.	13	13	4	5	4	3	-	-	-	1
Va.	48	35	20	24	196	91	438	475	30	30
W. Va.	2	4	5	6	18	19	59	81	4	5
N.C.	19	21	28	32	79	118	546	727	484	241
S.C.	9	4	11	21	42	159	125	221	17	33
Ga.	50	63	15	28	19	29	298	364	63	64
Fla.	86	82	100	93	120	99	2	188	21	11
E.S. CENTRAL	28	27	56	80	251	145	131	202	171	121
Ky.	4	8	11	17	67	45	21	37	2	2
Tenn.	7	5	15	24	135	68	36	100	88	65
Ala.	12	7	15	20	35	18	63	61	47	21
Miss.	5	7	15	19	14	14	11	4	34	33
W.S. CENTRAL	91	119	104	161	704	685	995	1,065	183	88
Ark.	7	4	16	14	63	44	46	25	105	31
La.	5	4	34	37	11	10	-	4	5	1
Okla.	7	4	9	16	33	82	96	181	71	42
Tex.	72	107	45	94	597	549	853	855	2	14
MOUNTAIN	46	38	58	83	1,445	920	206	172	25	9
Mont.	-	-	3	5	52	5	25	20	3	1
Idaho	1	1	7	7	38	73	8	15	4	2
Wyo.	-	1	3	2	30	124	6	6	5	2
Colo.	15	21	14	22	791	318	43	38	1	2
N. Mex.	4	3	7	9	130	67	5	5	2	1
Ariz.	13	7	12	29	202	181	108	69	2	-
Utah	8	4	5	1	164	118	8	14	8	1
Nev.	5	1	7	8	38	34	3	5	-	-
PACIFIC	147	181	272	295	1,545	2,200	171	219	5	1
Wash.	16	24	30	31	671	683	-	-	-	-
Oreg.	16	9	54	51	400	417	6	6	3	-
Calif.	110	141	178	194	441	1,023	157	204	2	1
Alaska	2	1	3	7	11	66	8	9	-	-
Hawaii	3	6	7	12	22	11	-	-	-	-
Guam	-	1	-	-	-	1	-	-	-	-
P.R.	-	2	8	10	6	4	56	66	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive: Drug resistant, all ages		*Streptococcus pneumoniae*, invasive: Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	35,433	38,435	10,594	20,691	3,990	5,049	1,812	1,754	617	619
NEW ENGLAND	1,814	1,900	265	301	161	421	55	89	59	8
Maine	80	120	5	6	8	27	2	-	3	-
N.H.	129	130	8	8	18	29	-	-	N	N
Vt.	56	65	3	7	8	19	8	6	3	4
Mass.	1,038	1,113	166	205	106	184	28	N	46	N
R.I.	107	114	18	14	21	14	17	10	7	4
Conn.	404	358	65	61	-	148	-	73	U	U
MID. ATLANTIC	4,939	4,391	1,038	2,131	639	863	117	117	107	87
Upstate N.Y.	1,128	1,022	392	470	213	325	51	63	76	65
N.Y. City	1,101	1,221	344	377	92	135	U	U	U	U
N.J.	872	736	213	327	145	160	-	-	6	2
Pa.	1,838	1,412	89	957	189	243	66	54	25	20
E.N. CENTRAL	4,389	5,114	985	1,668	781	1,170	422	383	149	273
Ohio	1,146	1,230	154	272	207	272	294	249	67	85
Ind.	532	500	189	149	93	110	128	134	38	26
Ill.	1,214	1,800	298	904	161	302	-	-	6	111
Mich.	788	718	194	226	271	333	N	N	N	N
Wis.	709	866	150	117	49	153	N	N	38	51
W.N. CENTRAL	2,169	2,234	385	718	274	307	17	18	98	66
Minn.	554	495	63	94	135	145	-	-	65	45
Iowa	401	350	61	73	N	N	N	N	N	N
Mo.	556	818	148	338	57	71	12	14	13	3
N. Dak.	41	36	3	7	11	16	-	3	4	7
S. Dak.	112	112	10	16	17	22	5	1	-	-
Nebr.	171	153	31	86	14	25	-	-	6	5
Kans.	334	270	69	104	40	28	N	N	10	6
S. ATLANTIC	9,874	9,744	2,390	6,102	767	824	897	941	51	18
Del.	81	95	6	161	3	6	4	1	N	N
Md.	747	771	139	540	150	203	-	24	38	-
D.C.	57	42	36	71	10	8	6	-	3	7
Va.	1,112	959	151	400	67	94	N	N	N	N
W. Va.	216	119	9	-	22	33	97	67	10	11
N.C.	1,457	1,199	341	898	118	94	N	N	U	U
S.C.	765	725	275	441	37	38	69	127	N	N
Ga.	1,672	1,858	561	1,089	156	163	207	209	N	N
Fla.	3,767	3,976	872	2,502	204	185	514	513	N	N
E.S. CENTRAL	2,292	2,667	727	912	189	179	120	127	5	-
Ky.	314	355	67	121	57	44	26	17	N	N
Tenn.	522	687	327	323	132	135	93	110	N	N
Ala.	672	687	287	301	-	-	-	-	N	N
Miss.	784	938	46	167	-	-	1	-	5	-
W.S. CENTRAL	2,961	5,591	2,364	5,328	228	254	55	68	107	103
Ark.	505	751	69	99	16	6	8	20	8	7
La.	710	804	248	423	2	1	47	48	25	21
Okla.	360	433	408	764	60	80	N	N	39	50
Tex.	1,386	3,603	1,639	4,042	150	167	N	N	35	25
MOUNTAIN	2,180	2,015	754	1,137	456	473	36	7	39	64
Mont.	179	103	4	2	-	1	-	-	-	-
Idaho	143	161	13	29	9	18	N	N	N	N
Wyo.	49	73	5	8	8	2	10	6	-	-
Colo.	499	446	145	298	123	123	-	-	36	48
N. Mex.	247	258	114	238	70	103	5	-	-	11
Ariz.	686	612	376	455	204	192	N	N	N	N
Utah	228	198	46	45	39	32	19	1	3	5
Nev.	149	164	51	62	3	2	2	-	-	-
PACIFIC	4,815	4,779	1,686	2,394	495	558	93	4	2	-
Wash.	523	513	101	150	53	56	-	-	N	N
Oreg.	377	380	69	205	N	N	N	N	N	N
Calif.	3,526	3,601	1,466	1,986	329	381	N	N	N	N
Alaska	55	83	6	10	-	-	-	-	N	N
Hawaii	334	202	44	43	113	121	93	4	2	-
Guam	-	40	-	34	-	-	-	-	-	-
P.R.	268	645	8	27	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 20, 2004, and November 15, 2003 (46th Week)*

Reporting area	Syphilis: Primary & secondary Cum. 2004	Syphilis: Primary & secondary Cum. 2003	Syphilis: Congenital Cum. 2004	Syphilis: Congenital Cum. 2003	Tuberculosis Cum. 2004	Tuberculosis Cum. 2003	Typhoid fever Cum. 2004	Typhoid fever Cum. 2003	Varicella (Chickenpox) Cum. 2004	Varicella (Chickenpox) Cum. 2003
UNITED STATES	6,524	6,225	295	385	9,504	10,938	252	322	15,673	14,705
NEW ENGLAND	164	189	5	1	318	373	19	26	607	2,914
Maine	2	7	-	-	-	19	-	-	180	773
N.H.	4	17	3	-	14	12	-	2	-	-
Vt.	-	1	-	-	-	9	-	-	427	688
Mass.	105	119	-	-	213	197	13	15	-	147
R.I.	22	20	1	-	29	43	1	2	-	5
Conn.	31	25	1	1	62	93	5	7	-	1,301
MID. ATLANTIC	860	775	39	59	1,800	1,958	58	72	77	38
Upstate N.Y.	85	38	5	9	234	261	8	12	-	-
N.Y. City	540	440	14	31	901	998	20	34	-	-
N.J.	128	160	19	19	382	392	15	21	-	-
Pa.	107	137	1	-	283	307	15	5	77	38
E.N. CENTRAL	751	800	55	69	1,044	1,019	17	32	5,213	5,079
Ohio	196	183	1	3	175	177	5	2	1,236	1,079
Ind.	50	41	9	12	113	115	-	4	61	-
Ill.	313	335	14	20	471	483	-	16	1	-
Mich.	163	225	31	33	208	186	10	10	3,523	3,148
Wis.	29	16	-	1	77	58	2	-	392	852
W.N. CENTRAL	133	133	5	4	391	415	9	6	130	74
Minn.	15	41	1	-	155	168	5	2	-	-
Iowa	5	8	-	-	33	30	-	2	N	N
Mo.	85	52	2	4	102	101	2	1	5	-
N. Dak.	-	2	-	-	4	4	-	-	82	74
S. Dak.	-	2	-	-	8	16	-	-	43	-
Nebr.	6	5	-	-	32	24	2	1	-	-
Kans.	22	23	2	-	57	72	-	-	-	-
S. ATLANTIC	1,700	1,637	45	75	2,032	2,165	41	51	1,956	1,951
Del.	8	6	-	-	-	23	-	-	4	29
Md.	310	275	7	12	215	217	11	9	-	1
D.C.	74	46	1	-	68	-	-	-	22	27
Va.	91	74	3	1	229	225	8	14	487	483
W. Va.	2	2	-	-	19	20	-	-	1,189	1,181
N.C.	168	139	10	16	260	285	7	9	N	N
S.C.	101	90	7	13	158	145	-	-	254	230
Ga.	296	431	1	13	315	461	5	6	-	-
Fla.	650	574	16	20	768	789	10	13	-	-
E.S. CENTRAL	354	291	19	12	483	619	7	6	-	-
Ky.	44	31	1	1	102	112	3	1	-	-
Tenn.	116	121	8	2	195	205	4	2	-	-
Ala.	147	106	8	7	153	202	-	3	-	-
Miss.	47	33	2	2	33	100	-	-	-	-
W.S. CENTRAL	1,041	826	48	70	925	1,594	19	30	5,389	4,106
Ark.	38	45	-	2	98	79	-	-	-	-
La.	243	151	-	1	-	-	-	-	48	16
Okla.	24	58	2	1	135	129	1	1	-	-
Tex.	736	572	46	66	692	1,386	18	29	5,341	4,090
MOUNTAIN	327	283	48	31	437	398	7	6	2,301	543
Mont.	-	-	-	-	4	5	-	-	-	-
Idaho	22	10	2	2	4	8	-	1	-	-
Wyo.	3	-	-	-	4	4	-	-	53	45
Colo.	38	34	-	3	94	93	2	3	1,754	-
N. Mex.	54	58	1	8	18	42	-	-	95	3
Ariz.	169	163	45	18	197	191	2	2	-	-
Utah	7	8	-	-	36	33	1	-	399	495
Nev.	34	10	-	-	80	22	2	-	-	-
PACIFIC	1,194	1,291	31	64	2,074	2,397	75	93	-	-
Wash.	124	70	-	-	203	212	6	3	-	-
Oreg.	25	40	-	-	74	95	2	4	-	-
Calif.	1,037	1,172	30	62	1,665	1,943	61	85	-	-
Alaska	1	1	-	-	35	49	-	-	-	-
Hawaii	7	8	1	2	97	98	6	1	-	-
Guam	-	1	-	-	-	48	-	-	-	143
P.R.	141	184	5	14	84	95	-	-	265	552
V.I.	4	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending November 20, 2004 (46th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	532	371	110	31	9	10	56
Boston, Mass.	126	73	32	11	5	5	14
Bridgeport, Conn.	31	26	3	2	-	-	3
Cambridge, Mass.	16	8	5	2	-	-	-
Fall River, Mass.	22	19	-	3	-	-	1
Hartford, Conn.	72	48	14	5	2	3	7
Lowell, Mass.	34	27	6	1	-	-	2
Lynn, Mass.	9	6	3	-	-	-	-
New Bedford, Mass.	26	19	7	-	-	-	1
New Haven, Conn.	54	36	14	3	-	1	8
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	3	-	3	-	-	-	-
Springfield, Mass.	54	45	6	1	1	1	5
Waterbury, Conn.	26	19	7	-	-	-	3
Worcester, Mass.	59	45	10	3	1	-	12
MID. ATLANTIC	2,149	1,429	484	162	36	37	117
Albany, N.Y.	51	33	12	3	-	3	2
Allentown, Pa.	30	21	7	2	-	-	-
Buffalo, N.Y.	U	U	U	U	U	U	U
Camden, N.J.	U	U	U	U	U	U	U
Elizabeth, N.J.	13	7	4	2	-	-	1
Erie, Pa.	48	37	8	2	1	-	5
Jersey City, N.J.	38	25	9	2	1	1	-
New York City, N.Y.	1,261	897	255	83	16	9	63
Newark, N.J.	60	32	15	9	3	1	2
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	293	110	110	40	12	21	12
Pittsburgh, Pa.§	U	U	U	U	U	U	U
Reading, Pa.	30	24	4	2	-	-	-
Rochester, N.Y.	152	112	30	7	2	1	19
Schenectady, N.Y.	20	18	2	-	-	-	1
Scranton, Pa.	28	23	4	1	-	-	2
Syracuse, N.Y.	69	51	11	5	1	1	7
Trenton, N.J.	33	22	9	2	-	-	-
Utica, N.Y.	23	17	4	2	-	-	3
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,164	1,467	458	142	39	57	158
Akron, Ohio	33	23	8	2	-	-	6
Canton, Ohio	47	38	4	3	-	2	3
Chicago, Ill.	376	237	91	27	9	11	27
Cincinnati, Ohio	71	52	8	6	2	3	9
Cleveland, Ohio	213	164	40	5	1	3	13
Columbus, Ohio	212	152	39	16	-	5	19
Dayton, Ohio	105	69	24	9	2	1	9
Detroit, Mich.	183	82	62	23	9	7	15
Evansville, Ind.	62	43	16	1	1	1	1
Fort Wayne, Ind.	59	40	12	3	1	3	5
Gary, Ind.	17	12	2	-	2	1	1
Grand Rapids, Mich.	53	35	14	1	1	2	5
Indianapolis, Ind.	199	124	44	19	3	9	12
Lansing, Mich.	71	53	16	1	1	-	4
Milwaukee, Wis.	124	84	25	10	1	4	7
Peoria, Ill.	41	33	6	1	-	1	4
Rockford, Ill.	52	32	12	5	3	-	2
South Bend, Ind.	71	58	7	4	1	1	5
Toledo, Ohio	103	81	13	5	2	2	7
Youngstown, Ohio	72	55	15	1	-	1	4
W.N. CENTRAL	549	383	99	39	15	13	31
Des Moines, Iowa	78	57	13	6	2	-	7
Duluth, Minn.	28	20	5	-	1	2	1
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	107	64	21	14	4	4	3
Lincoln, Nebr.	50	39	8	2	1	-	3
Minneapolis, Minn.	70	45	10	8	3	4	5
Omaha, Nebr.	90	68	15	3	3	1	5
St. Louis, Mo.	78	54	19	2	1	2	5
St. Paul, Minn.	48	36	8	4	-	-	2
Wichita, Kans.	U	U	U	U	U	U	U
S. ATLANTIC	836	534	202	66	19	14	49
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	130	80	31	18	1	-	15
Charlotte, N.C.	97	64	26	5	2	-	5
Jacksonville, Fla.	161	99	40	12	3	6	8
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	61	34	16	5	4	2	3
Richmond, Va.	67	40	17	4	4	2	4
Savannah, Ga.	68	48	15	3	2	-	2
St. Petersburg, Fla.	51	31	14	5	-	1	1
Tampa, Fla.	185	125	41	13	3	3	9
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	16	13	2	1	-	-	2
E.S. CENTRAL	634	412	151	38	17	16	44
Birmingham, Ala.	163	108	34	11	6	4	14
Chattanooga, Tenn.	73	52	14	4	1	2	7
Knoxville, Tenn.	U	U	U	U	U	U	U
Lexington, Ky.	66	42	17	2	1	4	5
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	102	64	27	6	3	2	5
Montgomery, Ala.	90	57	21	7	4	1	7
Nashville, Tenn.	140	89	38	8	2	3	6
W.S. CENTRAL	1,419	913	321	107	44	34	85
Austin, Tex.	75	38	23	6	4	4	5
Baton Rouge, La.	34	31	1	2	-	-	4
Corpus Christi, Tex.	59	42	14	1	1	1	3
Dallas, Tex.	218	122	49	28	8	11	10
El Paso, Tex.	U	U	U	U	U	U	U
Ft. Worth, Tex.	115	66	36	5	7	1	8
Houston, Tex.	414	262	92	37	14	9	26
Little Rock, Ark.	U	U	U	U	U	U	U
New Orleans, La.	46	34	12	-	-	-	-
San Antonio, Tex.	298	210	59	17	9	3	19
Shreveport, La.	39	25	10	2	-	2	-
Tulsa, Okla.	121	83	25	9	1	3	10
MOUNTAIN	877	564	187	74	27	25	55
Albuquerque, N.M.	124	80	26	13	2	3	7
Boise, Idaho	47	36	6	2	2	1	4
Colo. Springs, Colo.	65	37	18	2	3	5	3
Denver, Colo.	98	54	29	10	3	2	7
Las Vegas, Nev.	249	163	48	22	12	4	14
Ogden, Utah	31	23	7	1	-	-	1
Phoenix, Ariz.	89	63	13	9	2	2	3
Pueblo, Colo.	36	26	7	3	-	-	2
Salt Lake City, Utah	138	82	33	12	3	8	14
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,277	886	262	68	28	32	104
Berkeley, Calif.	17	13	3	-	-	1	1
Fresno, Calif.	118	87	20	7	3	1	5
Glendale, Calif.	20	17	3	-	-	-	1
Honolulu, Hawaii	90	67	18	2	-	3	9
Long Beach, Calif.	69	50	16	1	2	-	8
Los Angeles, Calif.	315	205	62	27	12	9	31
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	120	76	31	7	2	3	8
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	202	142	37	12	4	7	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	U	U	U	U	U	U	U
Seattle, Wash.	147	104	30	6	2	5	10
Spokane, Wash.	59	43	11	3	2	-	5
Tacoma, Wash.	120	82	31	3	1	3	7
TOTAL	10,437¶	6,959	2,274	727	234	238	699

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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